

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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Expedited Partner Therapy for Chlamydia and Gonorrhea

Chlamydia (CT) and gonorrhea (GC) remain the two most common reportable bacterial STD infections statewide. In 2005, California reported over 130,000 CT cases (over 38,000 in Los Angeles County) and over 34,000 GC cases (over 10,000 in Los Angeles County).

Both infections are associated with long-term sequelae: In females, these infections can cause pelvic inflammatory disease (PID), ectopic pregnancy, chronic pelvic pain, and infertility. Also, CT and GC can increase the risk of HIV acquisition in both males and females. These complications are more likely to occur with repeat infection.

Studies of CT and GC re-infection have shown rates ranging from 7%-25%. On average, re-infection rates within six months of treatment are approximately 11-13% in both males and females. The most common reason for re-infection, especially among females, is lack of partner treatment; most females who are positive for re-infection do not have a new sex partner. It can be difficult to get partners treated; they are often unable or unwilling to seek care. This is complicated by the fact that CT and even GC infections may be asymptomatic, leading partners to believe that they do not need treatment.

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Los Angeles HOPE: Investigating Fetal and Infant Mortality

Objective:

The Los Angeles Health Overview of a Pregnancy Event (L. A. HOPE) project is a survey of women who have experienced a fetal or infant loss within the county. Mothers are asked about their health, behaviors, and experiences before, during, and after their pregnancies. This self-reported information is combined with data from birth and death certificates to provide a complete picture. The objective of this project is to identify factors that may relate to fetal and infant loss. This project especially focuses on those factors that may be preventable and can be addressed through public health and system changes.

The initial L. A. HOPE project focused on those mothers living in Service Planning Areas (SPAs) 1 and 6, the Antelope Valley and South Los Angeles, respectively. It was conducted between October 2005 and July 2006. Overall, 50 of the 133 women contacted responded to the survey. Of those 50 cases, 27 (54%) were fetal death cases and 23 (46%) were infant death cases. All further results will be reported for fetal and infant death cases combined.

High Risk Pregnancies

Many of the women who participated in the L. A. HOPE project were at risk for poor birth outcomes before their pregnancies began. Specifically, 52% of respondents reported having at least one existing medical condition before becoming pregnant. Most common, 15 (30%) of the women were obese prior to becoming pregnant. Additionally, 52% had a previous fetal loss, 8% had a previous infant loss, and 16% and 20% had previously had a premature or low birth weight baby, respectively.

Conditions During Pregnancy

The responders also struggled with medical conditions during their pregnancies. Thirty-five (70%) women had some sort of medical anomaly. Most frequent, 19 (38%) had some sort of infection (kidney or bladder, group B streptococcus, periodontal disease, Bacterial Vaginosis, or another commonly transmitted sexual disease). Eighteen (36%) women had severe nausea, vomiting, or dehydration during their pregnancy. Additionally, 7 (14%) of the

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Treatment guidelines: Expedited Partner Therapy

The 2006 CDC STD Treatment Guidelines indicate that all sex partners from 60 days preceding diagnosis of CT or GC should be evaluated, tested, and treated. If the patient has had no partners in the previous 60 days, the most recent partner should be treated.

Traditional options for management of sex partners have been either provider referral or patient referral. Because providers often lack the resources necessary to notify the partners of CT and GC infected patients and there is concern that patient referral lacks effectiveness in getting partners notified and treated, a new partner management strategy called Expedited Partner Therapy (EPT) has emerged. EPT is defined as treatment of partners without intervening clinical assessment. This strategy bypasses obligatory clinical evaluation and professional counseling, and is a viable alternative to patient or provider-assisted referral.

There are several possible approaches to EPT. The most common is Patient Delivered Partner Therapy, or PDPT, which is delivery of medication or prescription to partner(s) by index patients. Other EPT options include pharmacy arrangements, field delivery by public health personnel, and medication pick-up by partners from providers' offices.

Recent data indicate that roughly half of U.S. clinicians have used EPT on an occasional basis, with about 5-10% of providers using EPT frequently or as their standard approach to partner management. In California, the practice of EPT appears to be more common, with about 50% of clinicians reporting that they "usually" or "always" used EPT to manage partners of patients with CT infection.

Effectiveness of Expedited Patient Therapy

The effectiveness of EPT was recently evaluated in 3 different CDC-funded randomized controlled trials. In a multi-center multi-venue trial (Schillinger et al., STD 2003), PDPT reduced rates of CT re-infection in women by 20%. The re-infection rate in the PDPT group (n=728) was 12% and the rate in the control patient referral group (n=726) was 15%. This result did not meet statistical significance.

However, in a second RCT involving men and women with CT or GC infection in the Seattle – King County area (Golden NEJM 2005), EPT reduced rates of re-infection with either CT or GC by 24%. Re-infection in the EPT group (n=929) was 9.9% while in the control group of provider or patient referral (n=931), the re-infection rate was 13%. These results were statistically significant. The reduction in re-infection was much greater for GC (73%) than for CT (15%).

In a third randomized clinical trial of males with urethritis (69% had CT or GC) taking place in New Orleans (Kissenger et al., CID 2005), PDPT reduced re-infection rates by 47%. Re-infection in the PDPT group (n=87) was 23% while in the control patient referral group (n=82) the re-infection rate was 43%. These results were also statistically significant.

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National Infant Immunization Week

During the week of April 21-28, 2007, the Department of Public Health will observe National Infant Immunization Week (NIIW), an annual opportunity to emphasize the need to fully immunize children age 2 years and younger against 14 vaccine-preventable diseases. This year, California's theme, "Up-to-date? Celebrate!" promotes the message that being up-to-date with immunizations is reason to celebrate.

High immunization coverage levels in a community translate into a community that is better protected against vaccine-preventable diseases. Vaccination coverage in California is at or near all-time high levels with roughly 3 in 4 children 19-35 months of age up-to-date on immunizations. However, childhood diseases still pose a serious threat to infants and toddlers, and complications of these diseases are often devastating to children and their families.

NIIW is a great time to celebrate children's up-to-date immunization status and promote timely immunizations as the best defense against vaccine-preventable diseases. We recognize the great work you are doing to immunize children and celebrate your continuous efforts to protect California's kids!

For more information about National Infant Immunization Week or for assistance with planning an NIIW event, please visit <http://www.immunizeca.org>.

Recommended Immunization Schedules (0 through 18 Years old)

In January of this year, the Advisory Committee on Immunization Practices for the CDC, in collaboration with the American Academy of Pediatrics, and the American Academy of Family Physicians, released the 2007 updated recommended immunization schedules for persons 0 through 18 years of age. Updated catch-up immunization schedules were also released.

For the first time, the immunization schedule is divided into two separate schedules: one for persons 0 through 6 years of age and another for persons 7 through 18 years of age. On the 7 through 18 years schedule, the 11 through 12 years column is in bold, capitalized fonts, to underscore the importance of the preadolescent visit when a child's complete immunization status should be reviewed and all necessary vaccines, including those recommended for persons 11 through 12 years of age, should be administered.


Following is a list of the other important changes in the immunization and catch-up immunization schedules since last year. The new schedules are attached on page 4.

- The new Rotavirus vaccine has been added to the immunization schedule for infants at 2, 4 and 6 months of age. The first dose should be administered at ages 6 through 12 weeks with subsequent doses administered at 4 - 10 week intervals. Rotavirus vaccination should not be administered after age 32 weeks.
- Influenza vaccine is now recommended routinely for children 6 - 59 months of age.
- The new varicella vaccine recommendation calls for two doses of vaccine for children without evidence of immunity. The first dose is given at 12 - 15 months of age and the second dose at 4 - 6 years of age; in addition, catch-up vaccination of older children who have not been vaccinated or have had only one dose is recommended.
- The new HPV vaccine is recommended for females at 11 - 12 years of age with catch-up vaccination of females 13 - 26 years of age who have not been vaccinated previously or who have not completed the full vaccine series. The HPV vaccine is a 3 dose series, with the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- The catch-up schedules for persons aged 4 months - 6 years and for persons aged 7 - 18 years now include the vaccines against Rotavirus (Rota), human papillomavirus (HPV), and varicella.

Nidhi Nakra, MPH
Immunization Program

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

| Vaccine▼ | Age► | Birth | 1 month | 2 months | 4 months | 6 months | 12 months | 15 months | 18 months | 19–23 months | 2–3 years | 4–6 years |
|---|------|-------|---------|----------------|----------|------------------|--------------------|-----------|-----------|--------------|-------------|-----------|
| Hepatitis B ¹ | | HepB | HepB | see footnote 1 | | HepB | | | | HepB Series | | |
| Rotavirus ² | | | | Rota | Rota | Rota | | | | | | |
| Diphtheria, Tetanus, Pertussis ³ | | | | DTaP | DTaP | DTaP | | DTaP | | | | DTaP |
| <i>Haemophilus influenzae</i> type b ⁴ | | | | Hib | Hib | Hib ⁴ | Hib | | Hib | | | |
| Pneumococcal ⁵ | | | | PCV | PCV | PCV | PCV | | | | PCV PPV | |
| Inactivated Poliovirus | | | | IPV | IPV | | IPV | | | | | IPV |
| Influenza ⁶ | | | | | | | Influenza (Yearly) | | | | | |
| Measles, Mumps, Rubella ⁷ | | | | | | | MMR | | | | | MMR |
| Varicella ⁸ | | | | | | | Varicella | | | | | Varicella |
| Hepatitis A ⁹ | | | | | | | HepA (2 doses) | | | | HepA Series | |
| Meningococcal ¹⁰ | | | | | | | | | | | MPSV4 | |

 Range of recommended ages

 Catch-up immunization

 Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and

other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). (Minimum age: 6 weeks)

- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHibit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])

- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). (Minimum age: 2 years)

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007

| Vaccine ▼ | Age ► | 7–10 years | 11–12 YEARS | 13–14 years | 15 years | 16–18 years |
|---|----------------|--------------|---------------------------|-------------|-------------------------|-------------|
| Tetanus, Diphtheria, Pertussis ¹ | see footnote 1 | | Tdap | | Tdap | |
| Human Papillomavirus ² | see footnote 2 | | HPV (3 doses) | | HPV Series | |
| Meningococcal ³ | | MPSV4 | MCV4 | | MCV4³ | MCV4 |
| Pneumococcal ⁴ | | | PPV | | | |
| Influenza ⁵ | | | Influenza (Yearly) | | | |
| Hepatitis A ⁶ | | | HepA Series | | | |
| Hepatitis B ⁷ | | | HepB Series | | | |
| Inactivated Poliovirus ⁸ | | | IPV Series | | | |
| Measles, Mumps, Rubella ⁹ | | | MMR Series | | | |
| Varicella ¹⁰ | | | Varicella Series | | | |

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components

of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)

- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. (Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). (Minimum age: 2 years)

- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). (Minimum age: birth)

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥4 weeks between the doses.

10. Varicella vaccine. (Minimum age: 12 months)

- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Therapy for Chlamydia and Gonorrhea...Continued from page 2

In addition to a reduction in re-infection rates, the 3 trials also showed that EPT had a positive impact on several behavioral outcomes. Patients randomized to EPT were equally or more likely to notify their partners than patients randomized to control groups. Patients randomized to EPT were at least equally and often more likely than control group patients to report that their partners had been treated, often confirming they had directly observed their partner taking the medication. Patients in the EPT groups were also less likely to report having sex with untreated partners as compared with control group patients.

EPT is at least equivalent to patient referral in preventing persistent/recurrent infection and promoting several desirable behavioral outcomes in heterosexual males and females with CT or GC. It is recommended as an option, but does not supplant other strategies when they are available. Written educational materials must accompany EPT and should warn about adverse medication effects along with advising recipients to seek personal health care in addition to EPT. This is especially important for female partners of male patients. While recent studies suggest that acute PID occurs in less than 5% of female contacts to males with CT and GC (Stekler, J et al., CID 2005), female partners that do have symptoms suggestive of acute PID such as abdominal or pelvic pain do need to seek medical attention.

Male partners should also seek care, especially if they have symptoms. This will prevent missing a diagnosis of epididymitis or co-infection with another STD. Data on the efficacy of EPT as a partner management strategy in MSM are currently lacking. There is also a high risk of STD co-morbidity in this population, especially HIV. Studies suggest that rate of undiagnosed HIV in MSM CT/GC contacts is around 6%. For these reasons, EPT for MSM should only be used selectively, and with caution, when other partner management strategies are impractical or unsuccessful.

In California, PDPT for chlamydia has been legal since January 1, 2001 (SB 648 Ortiz – Amended CA Health and Safety code section 120582 to allow for PDPT for CT). This law states that a physician may prescribe, and a nurse practitioner, nurse midwife, and physician assistant may dispense, prescription antibiotic drugs to the sexual partner(s) of a patient diagnosed with chlamydia infection, without requiring examination of the partner(s). Gonorrhea PDPT became legal on January 1, 2007 (AB 2280 Leno – Amended the same section of

the Health and Safety code to allow PDPT for GC and other STDs).

CA Guidelines for PDPT for CT are as follows:

- First-Choice Strategy: Attempt to bring partners in for evaluation and treatment
- Priority Patients: Females with male partners
- Partners: Males who are uninsured or unlikely to seek medical services
- Diagnosis: Laboratory-confirmed uncomplicated genital chlamydia infection
- Medication: Azithromycin (Zithromax*) 1 gram (250 mg tablets x 4) orally once
- Number of Doses: Limited to the number of known sex partners in the past 60 days
- Educational Materials: Must accompany medication
- Patient Counseling: Abstinence until 7 days after treatment, and until 7 days after partners have been treated
- Evaluation: Recommend that patients be retested for CT 3 to 4 months after treatment
- Adverse Reactions: Provider not protected from liability, as with any medical treatment. Report adverse reactions to the STDP Medical Director at (213) 744-3070.

Guidelines for PDPT for GC are still under development. Recommended medication will be Cefpodoxime 400 mg x 1, plus Azithromycin 1 g.

EPT can be an effective and useful partner management strategy. When used properly and under appropriate circumstances that complement the use of traditional partner management strategies, EPT can help reduce the significant burden of CT and GC found in CA and LA County.

Tracie McClain, MD MPH
STD Program

For more information:

CA Guidance on PDPT for CT:

http://www.stdhivtraining.org/pdf/PDT_GUIDELINES_19.pdf

CDC Information on EPT:

<http://www.cdc.gov/std/ept/default.htm>

Los Angeles HOPE...Continued from page 1

women needed to have a cerclage to compensate for an incompetent cervix and prevent preterm labor.

Prenatal care can be essential in helping women to overcome high risk pregnancies or medical conditions. However, 5 (10%) of the women in the study did not receive prenatal care until after their first trimester. Nineteen (38%) of the women did not have insurance before their pregnancy.

Labor and Delivery Issues

Thirty-one women (62%) had some type of delivery problem. Most frequently, the problem was early bleeding (38%) or premature rupture of membranes (28%) or early labor pains (24%). Overall, 78% of women had babies that were born low birth weight or premature. It is not surprising that the most common cause of death was prematurity (40%). Additionally, 26% of the babies had some form of congenital birth defect.

Psychosocial Issues

One of the benefits of surveying mothers is that it allows for the study of psychosocial factors, rather than focusing solely on medical issues. An astounding 86% of women (43) reported some sort of psychosocial factor. Seventy percent (35 women) suffered from depression or mental illness either during or immediately following their pregnancy. Sixty-two percent of the women experienced some sort of stressful life event such as having a family member in the hospital, getting divorced or separated, moving, being homeless, losing her job or her partner losing a job, going to jail or her partner going to jail, having a long commute to work, arguing more than usual with her partner, being physically abused or in a fight, experiencing financial problems, or having someone close to her struggle with drinking and drugs or die.

Grief and Bereavement

Given the extent of psychosocial issues preceding the loss of the baby, it is especially important that women be offered support following the loss of their babies. However, 16% of women were not offered any grief or bereavement materials, and 34% were not offered any information on support groups. On a more positive note, 20% of women received individual counseling, and 46% felt that their religion provided the best support.

Next Steps

The L. A. HOPE project is ongoing and being conducted throughout the county with a goal of obtaining 150 surveys during fiscal year 2006 to 2007. Additionally, information from the L. A. HOPE project will be compared to results from the Los Angeles Mommy and Baby (LAMB) survey of women who have delivered a healthy baby.

We are also collaborating with community groups to translate the results into action steps. This allows for a case-control analysis to determine factors that are more prevalent in pregnancies that results in fetal or infant loss.

For additional information, please see the website (www.lapublichealth.org/mch/lahope/lahope.html) or contact Margaret Chao at (213) 639-6470.

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Research Analyst I

During the week of April 21-28, 2007, the Department of Public Health will observe National Infant Immunization Week (NIIW), an annual opportunity to emphasize the need to fully immunize children age 2 and younger against 14 vaccine-preventable diseases. This year, California's theme, "Up-to-date? Celebrate!" promotes the message that being up-to-date with immunizations is reason to celebrate.

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THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County



COUNTY OF LOS ANGELES

Public Health

313 North Figueroa Street
Los Angeles, CA 90012

Selected Reportable Diseases (Cases)¹ — November 2006

| Disease | THIS PERIOD NOVEMBER 2006 | SAME PERIOD LAST YEAR NOVEMBER 2005 | YEAR TO DATE –NOV | | YEAR END TOTALS | | |
|---------------------------|---------------------------------|--|-------------------|--------|-----------------|--------|--------|
| | | | 2006 | 2005 | 2005 | 2004 | 2003 |
| AIDS ¹ | 150 | 134 | 1,255 | 1,412 | 1,516 | 2,210 | 2,443 |
| Amebiasis | 7 | 13 | 80 | 99 | 114 | 114 | 121 |
| Campylobacteriosis | 59 | 68 | 725 | 683 | 725 | 884 | 1,100 |
| Chlamydial Infections | 3,509 | 3,116 | 41,270 | 35,950 | 38,862 | 38,464 | 36,900 |
| Encephalitis | 5 | 1 | 42 | 43 | 57 | 133 | 38 |
| Gonorrhea | 893 | 893 | 10,611 | 9,643 | 10,494 | 9,696 | 8,078 |
| Hepatitis Type A | 2 | 114 | 341 | 372 | 480 | 321 | 374 |
| Hepatitis Type B, acute | 5 | 7 | 57 | 50 | 57 | 72 | 73 |
| Hepatitis Type C, acute | 0 | 1 | 4 | 2 | 3 | 5 | 0 |
| Measles | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| Meningitis, viral/aseptic | 28 | 30 | 346 | 484 | 515 | 807 | 899 |
| Meningococcal Infect. | 5 | 3 | 45 | 32 | 37 | 28 | 32 |
| Mumps | 0 | 1 | 7 | 9 | 8 | 2 | 10 |
| NGU | 55 | 64 | 728 | 1,035 | 1,101 | 1,470 | 1,410 |
| Pertussis | 4 | 7 | 138 | 364 | 438 | 156 | 130 |
| Rubella | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Salmonellosis | 90 | 72 | 1,129 | 1,012 | 1,085 | 1,205 | 995 |
| Shigellosis | 36 | 47 | 496 | 677 | 710 | 625 | 669 |
| Syphilis (prim. and sec.) | 58 | 58 | 679 | 582 | 646 | 470 | 468 |
| Syphilis early latent | 74 | 52 | 689 | 523 | 571 | 395 | 388 |
| Tuberculosis | 87 | 81 | 660 | 698 | 906 | 930 | 949 |
| Typhoid fever, Acute | 0 | 0 | 17 | 11 | 12 | 13 | 16 |

1. Case totals are provisional and may vary following periodic updates of the database.